Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KIRT REPP DC
PO BOX 9973
THE WOODLANDS TX 77387

Respondent Name
METROPOLITAN TRANSIT AUTHORITY

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-1647-01

MFDR Date Received
FEBRUARY 27, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "the denial rationales submitted by the carrier are without merit and rendered void as per my detailed rebuttal dated 04-26-2012."

Amount in Dispute: $3,835.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please dismiss this medical dispute. Needle EMGs are outside the scope of practice of a chiropractor. F-wave tests are not recommended by the ODG and the provider did not obtain preauth. The documentation does not support reimbursement for CPT code 95904."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2012	CPT Code 95864	$575.00	$0.00
	CPT Code 95903 (X8)	$295.00/each	$0.00
	CPT Code 95904 (X4)	$225.00/each	$367.36
TOTAL		$3,835.00	$367.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective May 2, 2006 requires preauthorization for specific healthcare treatments and services.
3. 28 Texas Administrative Code §137.100, effective January 18, 2007, sets out the use of the treatment

guidelines.

4. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
5. 22 Texas Administrative Code §75, effective December 24, 2009, *34 Texas Register 9208*, sets out the scope of practice for chiropractors.
6. District Court of Travis County, 250th Judicial District No. D-1-N-GN-06-003451, Honorable Stephen Yelenosky, Judge Presiding, Order on cross-motions for partial summary judgment dated November 24, 2009.
7. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012.
8. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Mandate dated August 8, 2013.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 170-Needle EMGs are outside of the chiropractor's scope of practice.
- 170-Payment is denied when performed/billed by this type of provider.
- 151-Payment adjusted because the payer deems the information submitted does not support this many services.
- 151-Documentation does not support this many units.
- 197-Payment denied/reduced for absence of precertification/authorization.
- 197-95903 NCS motor with F-wave study. F-wave test are not recommended by the ODG. As such, the treatment exceeds the ODG, therefore, preauthorization is required.

Litigation Background for Needle EMG and MUA

Portions of the Texas Board of Chiropractic Examiners rules of practice were challenged by the Texas Medical Association and the Texas Medical Board in 2009. At issue was whether 22 Texas Administrative Code §75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) were within the scope of chiropractic practice in Texas. Specifically, the parties sought judgment on whether rules allowing Chiropractors to perform needle electromyography (EMG) and manipulation under anesthesia (MUA) were valid. On November 24, 2009, the 345th District Court issued a judgment in which presiding judge Honorable Stephen Yelenosky concluded that needle EMG and MUA exceeded the statutory scope of chiropractic practice in Texas. The Texas Board of Chiropractic Examiners appealed the district court's judgment to the Texas Court of Appeals, Third District. The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice. The Chiropractic Board exhausted its appeals and on August 8, 2013, the mandate affirming the district court's judgment was issued. The mandate states "…we affirm the remainder of the district court's judgment that subparts 75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) of the Texas Board of Chiropractic Examiners' scope-of-practice rule are void." In accordance with the Texas Court of Appeals opinion, the final mandate, and the scope of chiropractic practice requirement in 28 Texas Administrative Code §134.203(a)(6), needle EMG and MUA services may not be reimbursed.

Issues

1. Is the rendering provider eligible to perform needle electromyography?
2. Is the rendering provider eligible to perform nerve conduction tests?
3. Does a preauthorization issue exist in this dispute?
4. Does the documentation support billed units of 95904?
5. Is the requestor entitled to reimbursement for 95904?

Findings

1. CPT code 95861 is defined as "Needle electromyography; 4 extremities with or without related paraspinal areas." According to the medical documentation found, this service was performed by Kirt Repp, D.C. (Doctor of Chiropractic). The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice of chiropractors. 28 Texas Administrative Code §134.203(a)(6) states "Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act." The division finds that disputed service code 95864 is not within the scope of chiropractic practice because it is an electro-diagnostic test that involves the insertion of a needle into the patient. Therefore, no reimbursement can be recommended for CPT code 95864 pursuant to 28 Texas Administrative Code §134.203(a)(6).
2. Disputed services 95903, and 95904 fall in the category of nerve conduction tests under applicable AMA current procedural terminology (CPT). These tests involve placing a stimulating electrode is directly over the

nerve to be tested. These are surface tests that do not involve needles. According to the medical documentation found, these services were performed by Kirt Repp, D.C. (Doctor of Chiropractic). As stated in the Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012

> In the second provision, paragraph(c)(3)(A), TBCE imposed certification and supervision requirements on any licenses who administered "electro-neuro diagnostic testing" that varied according to whether the testing was "surface (non-needle)" or involved the use of needles. The import or effect of paragraphs (c)(2)(D) and (c)(3)(A), as the parties agree, was that chiropractors with specified training and certification could utilize needle EMG in evaluating or examining patients. In their live petitions and summary-judgment motions, the Physician Parties challenged the validity of the two rule provisions **specifically addressing needle EMG** [emphasis added]- 75.17(c)(2)(D) and (c)(3)(A) – plus the general standard regarding use of needles-75.17(a)(3)."

That is, surface tests were not in question during this suit. Pursuant to §75.17(c)(3)(A) effective December 24, 2009, *34 Texas Register 9208*, services 95903, and 95904 are within the scope of chiropractic practice because they are surface tests.

3. The respondent denied reimbursement for CPT code 95903 based upon reason code "197."

   28 Texas Administrative Code §134.600(p)(12) requires preauthorization for "treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   The requestor billed CPT code 95903 for the diagnosis 847.0- neck sprain and strain and 847.2-lumbar sprain and strain.

   According to the Low Back and Neck and Upper Back Chapters of the Official Disability Guidelines (ODG), nerve conduction studies are not a recommended treatment; therefore, the disputed nerve conduction studies, CPT code 95903, required preauthorization. As a result a preauthorization issue exists and reimbursement is not recommended.

4. The requestor billed for sixteen (16) units of CPT code 95904 on the disputed date of service. The respondent paid for twelve (12) units and denied the remaining four (4) based upon reason code "151-Documentation does not support this many units."

   A review of the Electrodiagnostic Evaluation/EMG-NCS report indicates sensory testing of bilateral median, ulnar, radial, medial and lateral antebrachial cutaneous, superficial peroneal, saphenous and sural nerves; therefore, the documentation supports the number of units billed. As a result reimbursement is recommended for the four (4) additional units.

5. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2012 DWC conversion factor for this service is 54.86.

   The Medicare Conversion Factor is 34.0376.

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 77076, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

   The Medicare participating amount for code 95904 is $56.98.

   Using the above formula, the MAR is $91.84 per unit. The requestor is seeking reimbursement for four; therefore, $91.84 X 4 = $367.36.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $367.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $367.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/25/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.